

Houston Neuropsychology Associates, PLLC

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NEUROPSYCHOLOGICAL EVALUATION

Name:	John Reyna	Education:	7 years
Date of birth:	9/13/1947 (78)	Handedness:	Right
Date of exam:	6/1/2026	Marital status:	Married
Ethnicity:	Hispanic/Latino	Occupation:	Retired
Referral source:	Joan Manu, MSN		

Mr. Reyna’s neurology provider referred him for an objective assessment of cognitive decline. The results will describe his current level of functioning to inform diagnostic decision-making and treatment planning; this evaluation is not intended for other purposes. Information was obtained from a clinical interview and a review of available medical records. He was seen with his wife and brother.

PRESENTING PROBLEMS & REVIEW OF SYMPTOMS

Mr. Reyna denied cognitive concerns. According to his wife, he forgets to turn off the water, leaves the door open, and watches shows on television repeatedly. She also indicated that he frequently repeated himself, but that this improved once he got back on his blood pressure medication regimen. On 4/8/2026, he left the house without his cell phone, and he was gone for 8-13 hours. His wife reported this to the police, and Mr. Reyna was found confused, stating he was late to work. His blood pressure was high during this episode, but he did not go to the hospital. He also wandered from his home on 5/10/2026 and was found overheated and agitated.

Mr. Reyna’s wife took over his medication management because he was forgetting to take his medications. She also manages his appointments. She proactively took over their financial management at the neurologist’s recommendation, but prior issues were denied. He stopped driving after his event on 4/8/2026; his family indicated that he had gotten lost once before this. He does not shop or cook. This is not a significant change, but he now has no appetite, so he does not attempt to feed himself. He is independent for basic self-care activities, but his wife reminds him to shower.

Mr. Reyna reported a stable mood, and he denied suicidal ideation. His wife reported increased irritability and occasional episodes of agitation. His appetite is absent. However, he has only lost a little weight. He denied sleeping difficulties and reported a stable energy level. He mostly spends his time watching television.

The following symptoms were denied: hallucinations, sensory changes, Parkinsonian symptoms, incontinence, and REM sleep behavior disorder.

MEDICAL HISTORY

Conditions: hypertension, hyperlipidemia, atrial fibrillation, and prediabetes.

Surgeries: appendectomy.

Current medications: metoprolol, nifedipine, atorvastatin, and apixaban.

Neuroimaging: A brain MRI with and without contrast on 12/17/2022 reportedly showed mild atrophy and moderate chronic microvascular ischemic changes. A CT head without contrast on the same date reportedly also showed an asymmetric fullness along the left parasellar and cavernous region, possibly representing a mass or aneurysm.

Mental health: Reportedly unremarkable.

Substance use: He denied alcohol, nicotine, and other substance use. He denied a history of substance dependence.

Family history: No known family history of dementia. His mother had a stroke; she died at 89. His father had heart disease and died of prostate cancer in his 60s. He has 6 siblings, whose history is unremarkable.

SOCIAL, EDUCATIONAL, & OCCUPATIONAL HISTORY

Mr. Reyna was raised in Texas and is monolingual in English. He has been married for over 40 years (2nd marriage) and has 3 children (2 from his previous marriage). He lives with his wife.

He completed 7 or 8 years of education (he did not recall). He denied a history of learning difficulties. He left school for non-academic reasons.

He worked as a barber and then as an HVAC technician. He retired in 2020.

BEHAVIORAL OBSERVATIONS

My. Reyna arrived on time and was accompanied by his wife and brother. He was appropriately dressed and groomed. He ambulated independently. His conversational language comprehension and expressive speech were within normal expectations. However, he was markedly taciturn; he often only responded with one-word answers. His thought process was notable for memory impairment; he did not recall how many siblings or children he had, and he described his work history as “basic.” He presented with a euthymic mood and a flat affect.

He was only oriented to the city. He was not oriented to the year, month, date, day of the week, season, state, county, or specific location; he mostly responded: “I don’t know.” During testing, he appeared guarded and often stated that he did not know, without attempting to answer items. However, this was thought to be due to genuine cognitive dysfunction.

TESTS ADMINISTERED

Mini Mental Status Exam
Wide Range Achievement Test-5, Word Reading
Repeatable Battery for the Assessment of Neuropsychological Status
BDAE Complex Ideational Material
Neuropsychological Assessment Battery, Naming
Oral Trail Making Test
Clock Drawing
Geriatric Depression Scale-Short Form
Generalized Anxiety Disorder-7

RESULTS SUMMARY

This evaluation is considered a valid assessment of Mr. Reyna’s current neuropsychological functioning. Performance descriptors follow the AACN consensus conference statement on

uniform labeling of performance test scores. His MMSE was 10/30 (-9 orientation, -5 serial subtraction, -3 recall, -1 naming, -1 repetition, -1 writing).

Academic: Word reading was exceptionally low. Notably, when asked to write a sentence, he stated that he cannot write.

Attention & Processing Speed: Digit repetition was below average. Processing speed was exceptionally low for digit-symbol transcription and rote counting speed.

Executive Functioning: He was unable to perform number/letter set-shifting. Spontaneous clock drawing was grossly conceptually impaired.

Language: Object naming was exceptionally low (6/31 words). Semantic verbal fluency was exceptionally low. He accurately answered 10/12 yes/no paired items on an auditory comprehension measure (low average).

Visuospatial: Judgment of line orientation was within normal expectations. Simple figure copy was exceptionally low, but the figure gestalt was intact. Clock copy was grossly intact.

Learning & Memory: Word list learning was exceptionally low, and recall was nil. Recognition of list words was below average. Simple story registration was nil, and recall was nil. Simple figure recall was nil.

Mood/Behavior: He endorsed a normal level of depressive symptoms and no anxiety symptoms on self-report questionnaires that were read to him to ensure understanding.

CLINICAL IMPRESSIONS

Mr. Reyna's premorbid cognitive ability is estimated to be in the low average to below average range based on educational and occupational history, as well as performance on a word reading task that is generally robust to the effects of brain disease. His MMSE was 10/30, he was grossly disoriented, and his spontaneous clock drawing was grossly conceptually impaired. Relatedly, he exhibited impaired set-shifting, object naming, semantic fluency, information registration, and recall. His recall was nil, without benefit from cueing. He also exhibited poor attention and processing speed. In contrast, his auditory comprehension and visuospatial perception were relatively preserved. He denied mood symptoms, despite presenting with a flat affect, but his family described occasional mild agitation.

In summary, Mr. Reyna's cognitive profile was characterized by dense amnesic memory impairment, executive dysfunction, language deficits, and reduced processing speed. The report of symptoms and current results warrant a dementia diagnosis, and Alzheimer's disease is the primary etiology of consideration. Relatedly, he lacked insight. His neuroimaging reportedly showed moderate chronic cerebrovascular disease. This may be a contributing factor, but it would not fully explain his results. Fortunately, he currently appears to be receiving an appropriate level of assistance.

DIAGNOSTIC IMPRESSIONS

Dementia Due to Alzheimer's Disease, Moderate Severity, with Agitation

RECOMMENDATIONS

1. He appears to be a candidate for pharmacologic dementia treatment.

2. Pharmacologic mood management may be beneficial.
3. His family is encouraged to consider options for higher levels of care, such as home health or assisted living.
4. A trusted associate should continue accompanying him to appointments and be involved in decisions concerning his welfare. His retention of information is unlikely.
5. Documentation, such as a durable financial power of attorney, medical power of attorney, and an advanced care plan, should be in order and up to date.
6. Ongoing physical activity and engagement in enjoyable activities will remain important for optimizing his functioning.
7. He and his family may benefit from the following resources:
 - a. *The 36-Hour Day: A Family Guide to Caring for Persons with Alzheimer's Disease, Related Dementing Illness, and Memory Loss Later in Life* by Nancy L. Mace and Peter V. Rabins.
 - b. The Alzheimer's Association (<http://www.alz.org>).
 - c. The Caregiver Action Network, which provides educational videos about Alzheimer's disease, life as a caregiver, and finding support (<https://www.caregiveraction.org/alzheimers-videos/>).
 - d. The Family Caregiver Alliance (www.caregiver.org).
 - e. Amazing Place in Houston, TX, which is a day program and resource for further education, engaging activities, and caregiver support (<https://www.amazingplacehouston.org/>).

Thank you for this kind referral. Please do not hesitate to contact me if I can further assist.

Jesse Passler

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Board Certified, American Board of Clinical Neuropsychology